ATTACHMENT 1
ADA 2002 claim form completion instructions for dental services

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so in the Wisconsin Medicaid Dental Services Handbook.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for more information about the EVS.

HEADER INFORMATION

Element 1 — Type of Transaction (not required)

Element 2 — Predetermination/Preauthorization Number (required, if applicable)

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF), if applicable. Do not attach a copy of the PA/DRF to the claim. Services authorized under multiple PA requests must be submitted on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

PRIMARY PAYER INFORMATION

Element 3 — Name, Address, City, State, ZIP Code (not required)

OTHER COVERAGE

Element 4 — Other Dental or Medical Coverage? (not required)

Element 5 — Subscriber Name (Last, First, Middle Initial, Suffix) (not required)

Element 6 — Date of Birth (MM/DD/CCYY) (not required)

Element 7 — Gender (not required)

Element 8 — Subscriber Identifier (SSN or ID#) (not required)

Element 9 — Plan/Group Number (not required)

Element 10 — Relationship to Primary Subscriber (not required)

Element 11 — Other Carrier Name, Address, City, State, ZIP Code

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing Wisconsin Medicaid unless the service is not covered by commercial health insurance. Wisconsin Medicaid uses Element 11 to identify Medicare and commercial health insurance information, whether the recipient has commercial health insurance coverage, Medicare coverage, or both. Refer to the July 2003 *Wisconsin Medicaid and BadgerCare Update* (2003-50), titled "Changes to local codes, paper claims, and prior authorization for dental services as a result of HIPAA," (Attachments 6-13) for the following information:

- Wisconsin Medicaid commercial health or dental insurance explanation codes for use in Element 11 (Attachment 6).
- Medicare disclaimer codes (Attachment 7).
- A key to Wisconsin Medicaid's seven commercial health insurance indicators for use when a recipient's eligibility is confirmed in the EVS (Attachment 8).
- When the EVS indicates the code "DEN" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 9).
- When the EVS indicates the code "HMO" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 10).
- When the EVS indicates the code "VIS" for "Vision Only," providers are not required to bill private insurance.
- When the EVS indicates the codes "BLU," "WPS," "CHA," "HPP," or "OTH" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 12).
- When the EVS indicates the code "SUP" for "Medicare Supplement," providers must bill commercial insurance for Medicare-allowed services only (Attachment 11).
- Appropriate provider responses to special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid (Attachment 13).

Recipients with commercial health or dental insurance coverage

Commercial health or dental insurance coverage must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid. Commercial health insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When commercial dental or health insurance paid for some services

When commercial dental or health insurance paid only for some services and denied payment for the others, Wisconsin Medicaid recommends providers submit two separate Medicaid claim forms. To maximize Medicaid reimbursement, one claim should be submitted for the partially paid services and another for the services denied by commercial dental or health insurance.

Recipients with Medicare coverage

Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Do not enter a Medicare disclaimer code in Element 11 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.

- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. Refer to Attachment 7 of *Update* 2003-50 for a list of Medicare disclaimer codes.

Recipients with both Medicare and commercial dental or health insurance

Use both a Medicare disclaimer code (e.g., "M-5") and an other insurance explanation code (e.g., "OI-P") when applicable.

Note: The other carrier's address, city, state, and ZIP code are not required.

PRIMARY SUBSCRIBER INFORMATION

Element 12 — Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. The recipient's address, city, state, and ZIP code are not required.

Element 13 — Date of Birth (MM/DD/CCYY)

Enter the recipient's birth date in MM/DD/CCYY format (e.g., March 27, 1972, would be 03/27/1972).

Element 14 — Gender (not required)

Element 15 — Subscriber Identifier (SSN or ID#)

Enter the recipient's *10-digit* Medicaid identification number. Do not enter any other numbers or letters.

Element 16 — Plan/Group Number (not required)

Element 17 — Employer Name (not required)

PATIENT INFORMATION

Element 18 — Relationship to Primary Subscriber (not required)

Element 19 — Student Status (not required)

Element 20 — Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code (not required)

Element 21 — Date of Birth (MM/DD/CCYY) (not required)

Element 22 — Gender (not required)

Element 23 — Patient ID/Account # (Assigned by Dentist) (not required)

RECORD OF SERVICES PROVIDED

Element 24 — Procedure Date (MM/DD/CCYY)
Enter the date of service in MM/DD/CCYY format (e.g., November 1, 2003, would be 11/01/2003) for each detail.

Element 25 — Area of Oral Cavity
If the procedure applies to the repair of dentures or partials, the area of the oral cavity is entered here.

Element 26 — Tooth System (not required)

Element 27 — Tooth Number(s) or Letter(s)
If the procedure applies to only one tooth, the tooth number or tooth letter is entered here.

Element 28 — Tooth Surface
Enter the tooth surface(s) restored for each restoration.

Element 29 — Procedure Code
Enter the appropriate procedure code and modifier for the dental service provided.

Element 30 — Description
Write a brief description of each procedure.

Element 31 — Fee
Enter the usual and customary charge for each detail line of service.

Element 32 — Other Fee(s) (required for other insurance information, if applicable)
Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 32 is greater than zero, "OI-P" must be indicated in Element 11.) Do not include the Wisconsin Medicaid copayment amount. *If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement.* This allows Wisconsin Medicaid to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Element 33 — Total Fee
Enter the total of all detail charges. Do not subtract other insurance payments.

MISSING TEETH INFORMATION

Element 34 — Permanent and Primary (Place an 'X' on each missing tooth) (not required)

Element 35 — Remarks (required, if applicable)
List any unusual services, including reasons why limitations were exceeded. Providers should enter the word "Emergency" in this element for an emergency service.

AUTHORIZATIONS

Element 36 — Patient/Guardian Signature and Date (not required)

Element 37 — Subscriber Signature and Date (not required)

ANCILLARY CLAIM/TREATMENT INFORMATION

Element 38 — Place of Treatment (Check applicable box)
Check the appropriate box.

Element 39 — Number of Enclosures (00 to 99) (not required)

Element 40 — Is Treatment for Orthodontics? (not required)

Element 41 — Date Appliance Placed (MM/DD/CCYY) (not required)

Element 42 — Months of Treatment Remaining (not required)

Element 43 — Replacement of Prosthesis? (not required)

Element 44 — Date Prior Placement (MM/DD/CCYY) (not required)

Element 45 — Treatment Resulting from (Check applicable box) (required, if applicable)
Check appropriate box if the dental services were the result of an occupational illness/injury, auto accident, or other accident.

Element 46 — Date of Accident (MM/DD/CCYY) (required, if applicable)
If a box was checked in Element 45, enter the date the accident happened.

Element 47 — Auto Accident State (required, if applicable)
Enter the state where the auto accident occurred.

BILLING DENTIST OR DENTAL ENTITY

Element 48 — Name, Address, City, State, ZIP Code
Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and ZIP code. Enter the billing provider's complete city, state, and ZIP code as they appear on the Medicaid certification letter. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 48 must correspond with the provider identification number in Element 49.

If providers move or are at a different address, they should complete the Wisconsin Medicaid Provider Change of Address or Status form (HCF 1181) to notify Wisconsin Medicaid that an address change has occurred. The form is located on the provider forms section of the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Element 49 — Provider ID
Enter the billing provider's eight-digit Medicaid provider number. The provider number in this element must correspond with the provider name indicated in Element 48.

Element 50 — License Number (not required)

Element 51 — SSN or TIN (not required)

Element 52 — Phone Number (not required)

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Element 53 — Dentist's Signature Block

The provider or the authorized representative must sign in Element 53. The month, day, and year the form is signed must also be entered in MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with a date. However, claims with "signature on file" stamps are denied.

Element 54 — Provider ID

If Elements 48 and 49 indicate a clinic or group biller, indicate the Medicaid-certified treating provider's eight-digit Medicaid provider number in this element.

Element 55 — License Number (not required)

Element 56 — Address, City, State, ZIP Code (not required)

Element 57 — Phone Number (not required)

Element 58 — Treating Provider Specialty (not required)